



V I S I O N
P R O F E S S I O N A L S

**PRE-EXAMINATION QUESTIONNAIRE
(CHILD)**
Welcome to our practice!

Child's Name:	Birth Date: / /	Date: / /
Address:	Person Responsible for Account:	
City / State / Zip:	Name:	
Home Phone: () -	Method of Payment: (circle)	
Parent Cell Phone: () -	Cash / Check / VISA / MC / Discover	
Child Social Security #	Vision Insurance:	
School/Grade:	Medical Insurance:	
E-Mail:	Responsible Party Social Security #: - -	

How did you hear about our practice? _____
If referred by a current patient, please write their name on the line above so we may thank them.

List family members below and indicate if they are patients in our office:

Family Member	Age	Patient (yes/no)
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____

Is there a specific reason you decided to get your child's eyes checked? _____

Has your child ever had previous eyecare? When: _____ Whom: _____
Who is your child's physician/pediatrician? _____ Location: _____

EYE HEALTH & MEDICAL CONDITIONS

Circle Appropriate Answer		If Yes, please explain with additional information	
Yes	No	Was your child born more than 30 days premature?	<u>list weeks:</u> _____ <u>birth weight:</u> _____
Yes	No	Were there any pregnancy complications for child or mother?	_____
Yes	No	Was oxygen used after birth?	_____
Yes	No	Does your child have any developmental or neurological delays?	_____
Yes	No	Does your child have any medical conditions?	_____
Yes	No	Has your child ever worn glasses?	_____
Yes	No	Has your child been diagnosed with lazy eye or strabismus?	_____
Yes	No	Has your child ever worn an eye patch?	_____
Yes	No	Has your child had any form of vision therapy?	_____
Yes	No	Has your child ever had any eye injuries or accidents?	_____
Yes	No	Has your child ever undergone eye surgery?	_____
Yes	No	Do any relatives have any serious eye problems?	_____

Please list any medications or eyedrops your child uses: _____

Please list any allergies your child has: _____

Please list any other issues that may be pertinent to today's exam:

Does your child complain of (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> blur with distance viewing | <input type="checkbox"/> watery eyes | <input type="checkbox"/> tired eyes |
| <input type="checkbox"/> blur when reading at near | <input type="checkbox"/> red or blood-shot eyes | <input type="checkbox"/> headaches |
| <input type="checkbox"/> squinting | <input type="checkbox"/> burning or itching | <input type="checkbox"/> nausea or dizziness |
| <input type="checkbox"/> words running or jumping together | <input type="checkbox"/> encrusted eyelids | <input type="checkbox"/> double vision |
| <input type="checkbox"/> eye ache, hurt or pull | <input type="checkbox"/> frequent styes | <input type="checkbox"/> eyes turn in / out |
| | | <input type="checkbox"/> light bothering eyes |

List any activities that your child is involved in. Include sports, hobbies, interests, etc.

Is your child's schoolwork (circle one): Below Expectations Satisfactory Very Good

Does your child have problems in any subjects? Reading Writing Spelling Math History Science

Have you or anyone else frequently noted the following behaviors in your child (check all that apply)?

Binocular Vision Signs / Symptoms

- moves head rather than eyes while reading
- loses place, rereads or skips lines while reading
- uses finger marker to keep place while reading
- displays short attention span while reading or copying
- writes up or down hill on paper
- repeats letters within words when copying
- omits numbers, letters or phrases
- misaligns digits in number columns
- squints, closes or covers one eye when working
- tilts head extremely while working at desk or reading
- holds book or work too close to face
- blinks excessively at desk tasks and/or reading
- avoids near centered tasks
- makes errors copying from chalkboard to paper
- makes errors copying from one paper to another
- rubs eyes during or after visual activity

Perceptual Signs / Symptoms

- mistakes words with same or similar beginnings or endings
- fails to recognize same word in next sentence
- reverse letters and/or words in writing and copying
- fails to remember what he/she was read or told aloud
- says words aloud or lip reads while reading silently
- does not complete assignments
- uses excessive effort to achieve
- has difficulty with phonics
- lacks motivation
- confuses right and left
- has short attention span
- dislikes reading
- is hyperactive
- is easily distracted
- is easily frustrated
- is sloppy when doing work
- seems awkward / uncoordinated

Is your child interested in wearing contact lenses?	Yes	No		
Does your child have a back up pair of glasses?	Yes	No		
Does your child wear sunglasses?	Yes	No	prescription?	Yes / No

When you visit our practice you may be interested to know what we will do to ensure you clear, comfortable vision. We carefully examine your eyes to determine what lens correction, if any, is necessary to give you the vision you require for all the things you need to do. Second, we will conduct a binocular vision screening to determine how well your eyes work together as a team. Last but not least, we will perform a thorough examination of your eye health. We are sure you will recognize the importance of all these steps in order to provide you with great vision.

When we recommend eye care, we want you to fully understand the benefits that you can anticipate. Therefore, it is our policy to discuss with you the results of your eye examination and to make recommendations tailored to fit your personal needs.

During the examination:

1. Do not worry about making a mistake or giving a wrong answer.
2. Do not worry about your answers contradicting one another.
3. Do not be alarmed if for a few minutes your vision is getting worse instead of better.
4. Do not hesitate to tell the doctor if you are unable to answer his/her questions.

Parent / Responsible Party Signature: _____

Date _____